INDEPENDENT REVIEWERS OF TEXAS, INC.

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Date notice sent to all parties:
September 4, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
10 Sessions, 30 hours, of work conditioning (lumbar)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Chiropractic Examiner

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Cover sheet and working documents
Utilization review determination dated 07/26/12, 08/05/12
Handwritten note dated 12/10/10, 12/13/10, 02/15/11, 03/23/11, 03/27/12, 05/10/11, 05/15/12, 07/21/12, 08/01/11, 10/17/11
Evaluation dated 03/30/11, 04/20/11, 05/05/11, 05/16/11, 06/15/11, 06/17/11, 08/30/11, 08/31/11, 10/11/11, 10/31/11, 11/07/11, 03/08/12
MRI right shoulder dated 04/12/11, 05/18/11
Post myelogram CT lumbar spine 05/27/11
Nerve conduction study dated 04/19/11
Radiographic report dated 03/03/11, 12/05/11
History and physical dated 12/14/11
Operative report dated 12/14/11
Discharge summary dated12/14/11
Electrophysiological study dated 02/16/12
Computerized muscle testing dated 01/04/11, 03/23/11
Functional capacity evaluation dated 08/09/11, 06/22/12

CT lumbar spine dated 08/19/11
Clinical interview dated 01/07/11, 03/09/11
MRI cervical spine, thoracic spine, lumbar dated 01/24/11
Office visit note dated 02/03/11, 05/31/11, 06/28/12
Electrodiagnostic exam dated 02/03/11
CT thoracic spine dated 02/10/11

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was hit head-on by a car driving the wrong direction on a one-way road. The driver of the other vehicle did not survive. The patient sustained injuries to her neck and back as a result of the accident. Treatment to date includes physical therapy, steroid injections, medication management, diagnostic testing, and lumbar laminectomy L4-5 right with discectomy, foraminotomy, osteophytectomy and medial facetectomy on 12/14/11. EMG/NCV dated 02/16/12 revealed evidence for a possible right S1 radiculopathy. Functional capacity evaluation dated 06/22/12 indicates that PDL requirements are medium for frequent lifting and medium to medium heavy for occasional lifting. Current PDL is light-medium.

Initial request for work conditioning x 40 hours was non-certified on 07/26/12 noting that the request for 40 hours of a work conditioning program exceeds treatment guidelines and therefore, the request cannot be certified. Treatment guidelines would support up to 30 hours of a work conditioning program and at this time with the request being for 40 the treating provider's request cannot be certified. The denial was upheld on appeal dated 08/05/12 noting that the patient has completed approximately 22 sessions of physical therapy, but there is no evidence of functional improvement as a result of these sessions. No ER-verified PDA is found. There is no clear evidence that there is a plan agreed to by the employer and employee.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the request for work conditioning for the lumbar spine 40 hours 10 sessions is not recommended as medically necessary. The request is excessive as the Official Disability Guidelines support up to 30 hours of a work conditioning program. There is no specific, defined return to work goal provided as recommended by the Official Disability Guidelines. Given the current clinical data, the request is not indicated as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Low Back Chapter

Work conditioning, work hardening	Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty RTW program (see ODG Capabilities & Activity Modifications for Restricted Work), rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. See also Return to work, where the evidence presented for "real" work is far stronger than the evidence for "simulated" work. Also see Exercise, where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job. Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapy provider or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic back pain, when compared to usual care. However, there is no evidence of their efficacy for acute back pain. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. (Schonstein-*Cochrane*, 2003) See also Chronic pain programs (functional restoration programs), where there is strong evidence for selective use of programs offering comprehensive interdisciplinary/ multidisciplinary treatment, beyond just work hardening. Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work conditioning and work hardening are not intended for sequential use. They may be considered in the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work conditioning may be less likely to be effective than work hardening or interdisciplinary programs. (CARF, 2006) (Washington, 2006) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally

effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-*Cochrane*, 2008) Use of Functional Capacity Evaluations (FCEs) to evaluate return-to-work require validated tests. See the Fitness For Duty Chapter.

Other established guidelines: High quality prospective studies are lacking for Work Conditioning and Work Hardening, but there are consensus guidelines used by providers of these programs. The term "work hardening" was first introduced in the late 1970s (Matheson, 1985), with a description as a "work-oriented treatment program" with an outcome of improvement in productivity. An assessment is necessary, and activities include real or simulated work activities. (Lechner, 1994) The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on Practice. (AOTA, 1986) In 1988 the Commission for Accreditation of Rehabilitation Facilities (CARF) addressed standards, suggesting that the programs must be "highly structured and goal oriented." Services provided by a single practitioner were excluded from CARF accreditation for work hardening. (CARF, 1988) As CARF accreditation includes extensive administrative and organization standards, the Industrial Rehabilitation Advisory Committee of the American Physical Therapy Association (APTA) developed the Guidelines for Programs in Industrial Rehabilitation. (Helm-Williams, 1993) This was primarily to offer more flexibility. Types of programs in these guidelines are outlined below:

Single-Discipline Exercise Approaches: Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of nonoperative therapy between acute PT and interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT guidelines, which appear below the ODG WH criteria.

Interdisciplinary Work-Related Exercise Approaches Adding Psychological Support: These approaches, called Work Hardening (WH) programs, feature exercise therapy combined with some elements of psychological support (education, cognitive behavioral therapy, fear avoidance, belief training, stress management, etc.) that deal with mild-to-moderate psychological overlay accompanying the subacute pain/disability, not severe enough to meet criteria for chronic pain management or functional restoration programs. (Hoffman, 2007) See also Chronic pain programs (functional restoration programs). There has been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition back to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to successful return to work. Types of issues that are commonly addressed include anger at employer, fear of injury, fear of return to work, and interpersonal issues with co-workers or supervisors. The ODG WH criteria are outlined below.

Criteria for admission to a Work Hardening (WH) Program:

(1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a prescription has been provided.

(2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or

	occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment. (3) *Job demands:* A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits). (4) *Functional capacity evaluations (FCEs):* A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. (5) *Previous PT:* There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches. (6) *Rule out surgery:* The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery). (7) *Healing:* Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (8) *Other contraindications:* There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion. (9) *RTW plan:* A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities. (10) *Drug problems:* There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification. (11) *Program documentation:* The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions. (12) *Further mental health evaluation:* Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning. (13) *Supervision:* Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should

	provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff. (14) *Trial:* Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress. (15) *Concurrently working:* The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment. (16) *Conferences:* There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented. (17) *Voc rehab:* Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to. (18) *Post-injury cap:* The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs). (19) *Program timelines:* These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required. (20) *Discharge documentation:* At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence. (21) *Repetition:* Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. **ODG Work Conditioning (WC) Physical Therapy Guidelines** WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work. *Timelines:* 10 visits over 4 weeks, equivalent to up to 30 hours.